To: Station Captains for presentation to all providers Date: 02/02/02

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Please post x 30 days

Medical Director, MCFRS Jurisdictional Program

Re: Helpful "Pearls" from Lessons Learned, 3rd Instant Fax in a Series

As individual cases cross the desks of the QI office, we respond to improve outcome by identifying patterns in many of the cases we review. Most of the time, education is the solution to avoiding the pitfalls of underestimating medical problems.

Do you feel you know the definition of a <u>high risk chief complaint</u>, as opposed to signs of an unstable patient? A common problem is that while we are able to spot a sick patient across a room, we "tunnel vision" how a patient looks right now, without the perspective of the whole time frame of a complaint. Medics may give a patient a sense of security based on the present and are "talked out of going" or downgraded. Our jobs as medics include a sense of hindsight in addition to foresight. Recognition of potentially **High Risk complaints** and our limitations in diagnosis are essential. These complaints are those that point to dysfunction in a major organ system or its blood/nerve supply:

- **Breathing trouble** can be progressive, or fluctuating and is a priority
- An **altered mental status** has a HUGE differential diagnosis, and represents a stress or damage to the brain or its blood supply, hardly something to ignore
- **Syncope** (pass out) implies that supply of blood was interrupted to the point of impairing both sides of the cerebrum or the "awake center" in the brainstem
- Chest pain not only represents high risk if cardiac, but other causes can be fatal as well, such as pulmonary embolism or dissecting thoracic aorta
- **Focal neurological signs** (weakness on one side, spinal sensory deficit) imply either peripheral or central nervous system damage or interruption
- In the proper settings don't forget **back pain** or **abdominal pain**: Most are OK for BLS, some need ALS, but all need transport to a hospital for care
- Fever in the elderly and children could represent severe infections
- **Seizure** can herald one of several different of the above problems

The response to this knowledge is pretty straightforward

- High risk chief complaints force us to be cautious and our professional advice is to URGE patients, not just "give an offer", to go to the hospital
- If no immediate priority signs exist, BLS should not necessarily feel they must call for ALS, but expedite transport especially if medics are delayed
- Never "blow off" the complaints leading up to the 911 call itself, in favor of focusing only on the here and now, but rather use foresight